PROJECT DIRECT'S CHURCH OUTREACH PROGRAM: INNOVATIVE APPROACH TO DIABETES PREVENTION AND MANAGEMENT

By

Dorothea Smith Brock

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Approved by:

Content Reader: LaVerne Reid, PhD

Second Reader: William Williamson, MPH

University of North Carolina at Chapel Hill

Abstract

Diabetes places a significant health burden on the African American citizens of North Carolina, and throughout the country. It is important to develop appropriate strategies to reduce the burden of diabetes. For the last eight years, Project DIRECT (Diabetes Interventions Reaching and Educating Communities Together) has served as a demonstration project with the goal of identifying culturally sensitive and appropriate strategies to reduce the burden of diabetes among African Americans in Southeast Raleigh. This paper will outline the use of innovative outreach practices to the communities as part of Project DIRECT activities. Several strategies and tools were developed such as the Church Health Assessment Tool, the Church Health Action Plan and a Church Outreach Visit Summary sheet to assist staff and other professionals in working effectively with African American faith-based communities in health promotion

efforts. The strategies and tools developed are rooted in theory and best practice for community based health promotion as noted in works by J. Hatch, E. Eng and M. Tuggle.

Diabetes places a tremendous health burden on the citizens of North Carolina. Estimates from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that about 584,000 NC adults have diabetes. It is important to note that one third do not know that they have the disease. At the same time, modifiable risk factors for the disease, such as lack of exercise, obesity/overweight and unhealthy diet, have increased in the last decade. African Americans and other ethnic minorities have a higher prevalence of diagnosed and undiagnosed diabetes. The prevalence of diagnosed diabetes in the adult population increased 42% from 1995-2000 (4.5% vs. 6.4%). This represents approximately 389,000 people with diagnosed diabetes in North Carolina. The BRFSS survey only permits estimates of prevalence in white and African American residents in North Carolina. The estimated prevalence of diabetes among African-Americans is 1.5 times greater than among whites (9% vs. 5.6%).

In 2000, diabetes was the fifth leading cause of death among North Carolinians, contributing to 2,078 deaths as a primary cause and 5,938 deaths as a contributory cause. Diabetes is even more burdensome for some ethnic minority groups (African Americans, Native Americans, and Hispanics), the elderly and for persons of low socioeconomic status. Diabetes mortality and hospitalization rates in North Carolina are highest in the northeastern part of the state, where there are greater percentages of African Americans. In 2000, the age-adjusted mortality rate was 2.5 times higher among minority groups than among whites. (Diabetes in North Carolina, Diabetes Prevention and Control Program, 2001)

It is critically important to significantly increase the number of people who comply with the recommended guidelines for physical activity and eating patterns to reduce the disparity in the

number of African Americans diagnosed with diabetes. In addition, if strategies can be implemented to increase compliance with the guidelines such as diabetes self-management, the morbidity and mortality found in the African American will also decline. Project DIRECT is rooted in the best practice model of community outreach, community asset mapping and community mobilization theories. In partnership with the community of Southeast Raleigh, the project implemented community-based strategies designed to assist residents in making positive health choices to reduce their risk factors for diabetes and better management of their diabetes. The strategies are innovative because they derived from the community's input and evaluation of their own needs. The project's use of focus group, informal and formal community networks gave rise to the outreach to churches and other faith based communities.

Project DIRECT is a multi-year community diabetes demonstration project, funded primarily by the Centers for Disease Control and Prevention (CDC). It is the largest community-based diabetes project in the United States. The project's intent is to develop, implement, and evaluate strategies that can be incorporated into state-based diabetes control programs nationwide. DIRECT involves a partnership among the community of Southeast Raleigh, Wake County Human Services, North Carolina Department of Health and Human Services Division of Public Health and the CDC. The mission of the project is to reduce the burden of diabetes and its complications in an African American community through a community based project. The three main intervention components are health promotion, outreach, and diabetes care. Health Promotion workgroup encouraged the whole community of Southeast Raleigh to increase their physical activity and make healthier food choices. The Outreach workgroup focused on design and implementation of activities aimed at increasing awareness of diabetes, early identification diabetes screening and

referral for follow up care if need. The Diabetes workgroup help people already diagnosed with diabetes with diabetes self-management and assisted local healthcare providers with providing best practice care to persons with diabetes. A coordinator, in consultation with a workgroup, carried out the planning and implementation of activities for each area. Workgroups included individuals from the community, health professionals, and representatives of local organizations. A coalition supports the project in its mission. It involves key individuals and organizations in Southeast Raleigh and the surrounding area. The coalition includes representation from community leaders, business and industry, and community organizations such as Strengthening the Black Family, Inc. Strengthening The Black Family is a tax-exempt, non-profit, community-based networking organization with the purpose of improving the quality of life of African American families in Southeast Raleigh and Wake County. The coalition also involved the media, state and local health departments, and social service agencies. Professional organizations such as Old North State Medical Society the Masonic Lodges gave valuable support. The list also included, health care providers, pastors of local churches, fraternities and sororities, and university faculty members including North Carolina Central University, University of North Carolina at Chapel Hill and North Carolina State University. The preceding list of coalition members was in recognition of the research by the Guide to Community Preventive Services and others that concluded that health is the product of multiple levels of influence. These include genetic and biophysiologic processes, individual behaviors, and the context within which people live – the socio-cultural environment. A multi-level approach to community health requires us to take into consideration, and act upon, the way that the socio-cultural environment affects health. The components developed by DIRECT are based on this and best practices identified for treating and preventing diabetes, such as increasing awareness of diabetes, early identification of diabetes in high risk populations,

diabetes self management and provider education (CDC Diabetes Prevention and Control Best Practice 2001).

In the first year of the project, a qualitative approach to assess knowledge, attitudes and behaviors of the residents of Southeast Raleigh were conducted for the residents of Southeast Raleigh. The focus groups were designed to determine the appropriate messengers and methods to deliver health promotion concepts in the community. In addition, the identification of informal association within the community would be key to successful implementation and sustainability of the project. The focus group participants were recruited from a list generated by DIRECT staff, workgroup members, and professional contacts. There were 14 groups, in sizes ranging from 4 to 17 participants. The interview sessions averaged an hour and forty minutes. Most participants were offered $10.00 and refreshments for their participation in the focus groups. The focus group participants were stratified based on age, income, location of housing and membership in community or church organizations as representative of Southeast Raleigh. The focus group sample is also representative of those who share the largest burden of person diagnosed with for diabetes with regard to race, age and socio economic status (Promoting Healthy Behaviors in African-American Faith Communities: The Project DIRECT Experience, NCCU, 2001). The outcomes of the focus groups yielded valuable information on the direction the project should take in engaging the community of Southeast Raleigh in increasing awareness of diabetes for example through church bulletins and radio ads on the most listed radio station. In addition, the focus group respondents reported high levels of confidence in select individuals such as Dr. Alan Mass, a local physician and the pastor of their church. This is only two of the major themes occurring in the finding, this paper will focus on the recommended use of the

church as an important mode for delivering health education programs to address diabetes in this population.

Of special note is of the 109 participants in the focus group, 97% reported religious affiliation. Researchers Linda M. Chatters and Taylor of the University of Michigan, Rukmalie Jayakody of the Pennsylvania State University and Jeffrey S. Levin of Eastern Virginia Medical School examined six national studies done between 1976 and 1987 by the Institute for Social Research at Michigan. In the new research encompassing seven major studies, researchers reported generally higher levels of religious participation among African Americans. In a 1978 Quality of American Life survey, 30 percent of African Americans said they were very "religious minded''. The 1986 Americans' Changing Lives study found 39 percent of African Americans read religious materials at least once a week. In the same study, 80 percent of African Americans said religion was very important. The study also point out that people residing in southern states tend to be more religious and the majority of African Americans reside in the southern states. (1997 Lubbock Avalanche-Journal. Some material, 1997 The Associated Press). Another study in a 1999 found that African-American women scored higher than black men on six religious indicators: frequency of prayer, church attendance, and participation in religious activities. Ransdell in 1995 article Church-based health promotion: an untapped resource for women 65 and older, wrote that churches have a long history and foundation of caring to positively affect health behavior changes in a safe, supportive environment and defines church-based health promotion is a ''large-scale effort by the church community to improve the health of its members through any combination of education, screening, referral, treatment, and group support''.

In some communities, especially African Americans, the African American church has historically served as an advocate, encourager, and enabler of actions for advancement in the community (Hatch, Cunningham, Woods, & Snipes, 1986). The church also promotes physical and mental health for the community, as well as meeting the spiritual needs of the congregation. The black church is one place in society where African Americans could hold leadership positions and influence each other towards positive goals such as missions for the needy in the community. In addition, Tuggle (1995) documents that the church has been the center of the communities, social, political, and educational functions for African Americans since the early 1900's. Eng, Hatch and Callen (1985) found that church based health promotion can provide education, screenings, referrals, and the existence of social networks and social support through churches provides a context for health promotion programming. In the African American church, social support is provided to the congregation and surrounding community to assist in overcoming social and political barriers to unequal access to resources including health (Institutionalizing social support through the church and into the community, 1985)

Women, older adults, persons with lower incomes and less education, and minorities are typically the least physically active. Promotion of physical activity is particularly important in improving health as a means to reduce risk of diabetes and many other chronic diseases, such as, cardiovascular disease, osteoporosis, hypertension, obesity, and certain cancers (Behavior Risk Factor Surveillance System, 2001), (Ransdell, 1998). In a 1990 study of lay health advisors by Wells, DePue, Lasater, and Carelton, the researchers found that traditional exercise and, fitness programs and individually focused approaches have not been adequate in encouraging consistent physical activity in women and minority populations. However, church based health promotions

including physical activity programs have shown promise in promoting health in individuals and communities. While church attendance of it self have been linked to good health, the social support provided by the church lay health advisors influences individual and group behavior. In a follow up to the 1990 study by Well, DePue, Lasater and Carelton, DePue, trained 220 volunteers from 16 churches to conduct risk factor change programs. The volunteers from the churches were eager to use their new skills. The participants were more likely to self manage their own health and provide education and social support to others. As with physical activity, church based efforts towards healthy eating habits can prove to be effective in encouraging individuals and communities to adopt healthier eating patterns for the prevention and management of chronic diseases such as diabetes. Whereas there does not appear to be significant differences, in mean daily intake between blacks and whites, considerable ethnic and geographic differences regarding which fruit and vegetables are consumed and how they are prepared are evident. The North Carolina Black Churches United for Better Health Project showed an increase in fruit and vegetable consumption of congregation members over a four-year intervention trial. (Campbell et al., 2000). The project engaged pastors from over 50 rural churches across the state. The project developed religious based materials supporting healthy eating taken from bible versus. In addition, church nutrition trainings were offered to assist church members in preparing healthier meals for church functions. One unique initiatives was to encourage churches to grow a vegetable garden to be available to church members and needy families in the area.

Based on the information from the focus groups that a large portion of Southeast Raleigh residents are likely to be involved in a church and relying on past research in faith based health promotion efforts, Dr. John Hatch, the project investigator theorized that working with churches

would assist in increasing participation in the projects activities and assist in institutionalizing health promotion efforts within the community. Project DIRECT staff needed to develop meaningful relationship with the predominately African American faith communities likely to have large members from Southeast Raleigh in order to implement initiatives. Dr. Hatch found is that the churches within the target population reflect the diversity of the target community. While membership is open to everyone, congregations tend to attract and serve people from similar economic and educational backgrounds. Some church memberships are mostly composed of upper middle class families while others serve mostly middle to lower middle class families. In North Carolina about 65-70 percent of African Americans who claim church affiliation, belong to one of seven national denominations controlled by African Americans such as Church of God in Christ. Others hold memberships in African American congregations affiliated with predominately white national denominations as with Baptist and Methodist churches, autonomous independent African American congregations and independent congregations. The result of Dr. Hatch's work is a Topology of Churches to describe his theory on this phenomenon. The topology developed also documents the appropriate and necessary strategies for recruiting churches. Equipped with this information the staff along with workgroup members designed several church based initiatives such as a walking program – "Ready, Set, Walk" and Church Nutrition Training to train church members on how to alter traditional recipes to be more healthy. While the activities were designed for the church setting, the next crucial step is to recruit churches to participate in DIRECT activities. The Outreach workgroup along with the project investigator and the NCCU Health Education Department developed strategies for recruiting churches to participate in interventions.

As discovered in the Black Churches United for Better Health 5 A Day project, and The Fitness through churches project, it is important to develop a trusting and meaningful relationship with the pastor and the congregation. Initial and frequent visits to churches assisted in facilitating a working relationship. It is important to note that churches required different strategies based on the how the church was organized as described above in Dr. Hatch's topology. For instance, fewer contacts were necessary to elicit responses from large churches with national affiliations or the strategic use of a "gate keeper" with affiliation with a large church organization, than from the loosely formed non-affiliated churches. Some churches required three or more contacts. A contact maybe includes Sunday visits to the church, attending bible study meeting or meetings with congregation members. Often this was necessary before a formal meeting with the pastor. Based on the previous research in working with churches on health promotion efforts an innovative strategy was developed to obtain base line information on a church obtained during an initial visit. The summary is completed during a Sunday church service. The visitor to the church completes a visual survey. The visitor notes the number of people in attendance, their approximate age range, and types of vehicles in the parking lot to gauge socio-economic status. In addition, project personnel note the names of leaders that are regularly posted in the bulletin; the Church Outreach Coordinator will contact these leaders later. The summary collects demographic information as well as. The members of the Outreach Workgroup regularly participated in completing a church visit summary for all the twenty-two churches included in this project. It required varying degrees of effort to recruit the 42 churches that participated in one or more Project DIRECT activities. In larger churches with national affiliations Dr. John Hatch, and Dr. LaVerne Reid, faculty from North Carolina Central University, Department of Health Education, designed a unique tool entitled the Congregational Health Assessment Tool (CHAT). The CHAT provides a non-

categorical assessment of a church's demographics and cumulative health-related information. The tool is adapted from Dr. Hatch's earlier work with the Lutheran Brotherhood " How to start a health ministry program", 1985. It also includes identification of assets to fulfill health-promoting activities as reported by the pastor and/or their designee. This activity as well as other strategies developed and implemented were to increase participation and facilitate institutionalization of health promoting activities within the African-American churches in Southeast Raleigh. The Congregational Health Assessment Tool and the follow up companion, the Church Health Action Plan are designed to engage ministers and other church leaders in a dialogue that will enhance technical knowledge of health-promoting behavior within a congregation. Given that churches receive multiple requests to participate in causes related to health behavior, this information enables churches to engage in needs-based planning. Each faith community successfully completing the Congregational Health Assessment Tool receives a copy of the Congregational Health Assessment Plan Program Guide: A Resource Manual for Developing Plans of Action and Establishing Health Ministries. This manual was developed to assist congregations in their efforts to address identified health concerns. The seven sections outline the role of the church in health promotion activities and provide a profile of each individual congregation and tailored recommendations from the CHAT needs assessment. The outcome behavior change of the tool is yet to be seen. Implementation of the CHAT and CHAP is exclusive to Project DIRECT. Preliminary results are promising as noted in the follow up evaluation conducted by the State Diabetes Prevention and Control evaluator. The strengths are inherent; churches and faith organizations can make informed decisions and develop strategies to prioritize the attention given to health issues that are important to their congregation. The principle weakness is the long time needed to engage churches from the initial church visit to a comprehensive meeting with the

church leadership. In some cases three to six months worth of follow up and contacts are necessary before a CHAT is completed and additional time is needed for the CHAP.

A representative sample of Southeast Raleigh's population provided input by way of the focus groups into the design and implementation of Project DIRECT activities. Project DIRECT staff implemented church based initiatives because the community sample was likely to be involved in a religious institution, had respect for the institution and was more likely to participate in health promotion programs if they were offered through the church. This is innovative because the community assisted in designing interventions that would enable them to address their own health problems, namely diabetes. Assisting a community in designing programs to meet their needs leads to increased participation as evident by the participation of the community prior to church based efforts compared with participation following church based programs. It is noted that helping a faith community develop its capacity for self-help includes several stages of development, as with communities, progress may be slow. *The Community Development Process: A Rediscovery of Local Initiative*, William and Loureide Biddle defines six stages in the community development process that seem common to projects in many different populations especially the African American Church. The time needed for the church group, to pass through these stages varies from months to years. Figuring out how to take action means making a detailed list of all the activities or steps that must be done for a particular action. The model is exhibited in the Project DIRECT church based outreach activities. It is effective in recruiting churches to participate in health promoting activities sponsored by DIRECT, thus contributing to its success in engaging a predominately African American population in efforts to reduce the incidence of diabetes. The Project is in its eighth year and will be completing an external evaluation to discover if indeed

there was an increase in community awareness of diabetes, an increase in early identification of those at high risk as reported by provider visits and an increase in diabetes self management as influenced by education, support and provider continuing education. The hope is that the church based efforts will lead to a permanent adoption of health programs in the church and pave the way for other health promoting organizations to work with the church.

The price of success involves time, resources and appropriate engagement of the community. The following is a review of needs to implement such an undertaking successfully. Staff training is necessary to effectively engage the community to identify their needs. While focus groups were used in this model, there are many others, which may yield reliable results. In addition faith-based health promotion strategies are labor intensive and are often faced with time limitations. It is imperative to find the appropriate messenger for implementing faith-based health promotions strategies in hard-to-reach sectors of the faith community. There are several major barriers to utilization of CHAT and CHAP. The first deals with administrative and logistical matters as with staff devoting the time to visit churches on Sunday. The second focuses upon practice orientation and expectancy outcomes. The third barrier describes the time commitment required to effectively implement faith based health promotion activities (Promoting Healthy Behaviors in African American Faith Communities; The Project DIRECT Experience, 2000).

In conclusion the literature supports that engaging a community in identifying its own needs assist in better program design and outcomes. It also utilizes existing assets of the community such as churches and other like institutions on which the community relies on and trust.

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